LONG-TERM SERVICES & SUPPORT (LTSS) SUBCOMMITTEE MEETING MINUTES

Meeting Date: 07/15/14

Meeting Location: Chicago, Springfield, conference call

Approval: FINAL

Governor's Office of Health Innovation and Transformation
100 W Randolph St, Chicago, IL 60601
Suite 2-201
312.814.1600

1. ATTENDANCE

Name	Title	Organization	Present
Lorrie Rickman-Jones	Sr. Policy Advisor for Behavioral Health, Services and Supports Workgroup Co-Chair	Office of the Governor	Chicago
Lora McCurdy	MFP & BIP Project Director, LTSS Subcommittee Chair	Illinois Department of Healthcare and Family Services	Chicago
Steve Lutzky	President, LTSS Subcommittee Subject Matter Expert	HCBS Strategies, Inc.	Chicago
Gwyn Volk	Director, LTSS Subcommittee Subject Matter Expert	Navigant Consulting	Chicago
Peter Eckart	Director of Health and Information Technology, LTSS Subcommittee Coordinator	Illinois Public Health Institute (IPHI)	Chicago
Ellen Kaufmann	Program Assistant, LTSS Subcommittee Coordinator	Illinois Public Health Institute (IPHI)	Chicago
Shea Ako	Parent	MFTD Waiver Families	Chicago
Sandra Alexander	Planning & Research Division Manager	Illinois Department on Aging	Chicago
Suzanne Andriukaitis	Williams Outreach Project Director	NAMI Chicago	Chicago
Sherie Arriazola	Health Policy Administrator	TASC, Inc. (Treatment Alternatives for Safe Communities)	Chicago
Jessie Beebe	Health Services Specialist	AIDS Foundation of Chicago	Chicago
Becky Brasfield		Sacred Creations	Chicago
Tameshia Bridges Mansfield	Midwest Program and Policy Manager	Phi National	Chicago
Michael Chavers	Executive Director	Indian Oaks Academy	Chicago
Suzanne Courtheoux	Supervisory Attorney - Consumer Practice Group	Legal Assistance Foundation (LAF) - Chicago	Chicago
Christian Denes	Senior Policy Analyst	Chicago Department of Family and Support Services	Chicago
Art Dykstra	CEO	Trinity Services, Inc.	Chicago
Ramon Gardenhire	Deputy Policy Director	SEIU Healthcare Illinois Indiana	Chicago
Iliana Gilliland	Director of Care	AIDS Foundation of Chicago	Chicago
Barb Haller		Illinois Hospital Association	Chicago
Brady Harden	Housing Coordinator	GOHIT	Chicago
Jon Hofacker	Intern	Health and Medicine Policy Research Group	Chicago
Juanita Irizarry	Housing Coordinator	GOHIT	Chicago
Nicole Jorwic	CEO	Institute on Public Policy for People with Disabilities	Chicago
Srujana Kunapareddy	In Person Counselor Program Manager	Illinois Coalition for Immigrant and Refugee Rights (ICIRR)	Chicago
Lydia Manning	Associate Professor of Gerontology Gerontology Program Faculty Leader	Concordia University Chicago Division of Human Services	Chicago
Mary McGinnis	Director of Operations	GOHIT	Chicago
Phyllis Mitzen	Margie Schaps (point person)	Health and Medicine Policy Research Group	Chicago

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Becky Newcomer	Director of Programs	One Hope United	Chicago
Heather O'Donnell	Vice President, Public Policy and Advocacy	Thresholds	Chicago
Dan Ohler	Vice President Government Solutions	Optum Health Care Technology	Chicago
Heidi Ortolaza-Alvear	Policy Intern	Chicago Department of Family and Support Services	Chicago
Tony Paulauski	Executive Director	The Arc of Illinois	Chicago
Kristen Pavle	Director, Long-Term Services and Supports	Community Care Alliance of Illinois	Chicago
Melissa Picciola	Staff Attorney	Equip for Equality	Chicago
Viviana Ploper	Vice President Chicldren and Family Services	Community Counseling Ctrs. of Chicago	Chicago
Sharon Post	Director, Center for Long-Term Care Reform	Health and Medicine Policy Research Group	Chicago
Laura Prohov	Judith Gethner point person	CJE Senior Life representing the Jewish Federation of Metropolitan Chicago	Chicago
Dorelia Rivera	Senior Policy Advisor	Illinois Department of Human Services	Chicago
Phyllis Russell	Executive Director	Association of Community Mental Health Authorities of Illinois (ACMHAI)	Chicago
Amy Rynell	Senior Director, Research & Policy	Heartland Alliance for Human Needs & Human Rights	Chicago
Tim Sheehan	Executive Director - Behavioral Health	Lutheran Social Services of Illinois	Chicago
Ruth Ann Sikora	Member	Illinois Autism Task Force	Chicago
Dr. Richard Smith	Consultant	DHS/DMH-Region#1 + CURE-IL	Chicago
Kate Speiser	Director of Clinical Services	Helping Hand Center	Chicago
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Marylynn Clarke	Senior Director	Illinois Hospital Association	Springfield
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2. MEETING LOGISTICS

Building: Chicago, JRTC / Springfield, Bloom Building

Conference Room: Chicago, Room 2-025 / Springfield, Large 3rd Floor Conference Room

Remote Access Tools Used: Dial-In 888-494-4032 pc 129 237 6808

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3. MEETING START

Meeting Schedule Start: 9:30 AM

Meeting Actual Start: 9:33 AM

Meeting Scribe: Ellen Kaufmann

4. AGENDA

WELCOME AND INTRODUCTIONS

- Phone participants asked to send email to gov.services.gohit@illinois.gov to recognize their attendance

STRUCTURE

- Services and Supports Workgroup divided into 2 subcommittees: LTSS and Children's Services
- LTSS Subcommittee further divided into breakthrough groups:
    - Will begin with 2: Service Definitions / Provider Qualifications and Conflict-free Case Management / Person-centered Planning
    - Anticipate additional breakthrough groups

STAKEHOLDER PARTICIPATION

- Alignment with Balancing Incentives Program (BIP) stakeholder group and Inter-agency Waiver Workgroup
- Asked participants to share suggestions for effective stakeholder engagement
- Comments and Q&A
    - C – 1115 waiver contains framework and commitment to maintain and expand services to individuals, it would benefit this group to know the framework of those services moving forward, help us to know the expectations. A lot of comments were summarized; summaries should come along forward, shoot to answer some of those concerns, and help guide us.
    - Q – Waivers do not include mental health (MH) populations, what is the breadth of definitions?
        - A: The MH population doesn't have a waiver, but looking at people holistically, people with mental illnesses and other issues are included in current waiver population. Also, BIP applies to people with serious mental illness, Conflict-free Case Management (CFCM) applies to all populations, BIP is broader than waivers.

- Q – Does the services and supports discussion include both Medicaid and non-Medicaid reimbursable LTSS?
  - A: Yes, federal Person-centered Planning requirements address natural supports; they are not broken down by Medicaid-only.
- Q – As a subcommittee, are we expected to make consensus on recommendations? Do recommendations go through filter of GOHIT before going into implementation plan?
  - A: Yes and yes, we would love to have consensus on recommendations from this group. May not be able to achieve it at all times, but we certainly want to make sure all voices are heard. Recommendations will go through GOHIT executive advisory committee, go through filter of state agency directors and Governor's Office.

LEVEL-SETTING:

- **SUBCOMMITTEE GOALS**
  - Timelines
    - BIP CFCM protocol due to Centers for Medicare and Medicaid (CMS) by October 31, 2014.
    - Transition plan for complying with new CMS HCBS Waiver regulations. Transition Plan is due to CMS on March 17, 2015.
    - Feedback to GOHIT for implementation of 1115 due in January 2015.
  - Trying to coordinate drivers and stakeholder processes
- **PERSON-CENTERED PLANNING AND CONFLICT-FREE CASE MANAGEMENT**
  - Person-centered Planning requirements effective March 17, 2014, most states out of compliance, CMS has provided some guidance for complying with the new regulations. Additional CMS guidance is expected soon.
  - Person-centered Planning requires getting to know individuals, identify goals and outcomes, Medicaid-funded services are one of many options, dramatic change
  - Suggestions include more standardization across support planning tools, across waivers
  - Flexibility, goals drive development of support plan vs. existing service packages
  - Medicaid Home & Community Based Services (HCBS) Rule presents minimum requirements for Person-centered Planning
  - Coordinated response to CFCM requirements for CMS HCBS Rule and BIP
- Comments and Q&A:
  - C – Clarification that State has one year to implement, and is not based on waiver renewal
  - C – Concern that standardized format is counterintuitive to PCP

- C – Person-centered Planning must involve person and actual conversations with the person and family, if processes become too mechanical, we can miss that, required interaction with person and family is a key component
- Q – In criminal justice system, if a defendant believes behavior stems from substance abuse, bring in TASC for assessment. BIP also has level 1 and 2 screening for assessment. Trying to avoid double assessments, how does that fit into LTSS and Medicaid managed care?
  - A: Will delve deeper into person flow for managed care and LTSS in future breakthrough meeting
  - A: Have clarified with CMS that these requirements apply to managed care
- C – When families step up to be part of the plan, they are not always informed. They are part of process, but not always sure of the choices. They can state needs, but aren't aware of all opportunities. Many families do not know waiver manual exists. "Informed" component is a true concern.
- Q – How does this process integrate with systemic change with hospitals and physicians? That change does not permit this in practice, difficult to have Person-centered Planning.
  - A: Excellent topic for future meetings
  - A: It would be a requirement for the Managed Care contract
  - A: This issue interfaces with the Integrated Delivery System Reform Workgroup and the roll out of model test plans
  - A: BIP funding proposal from Department on Aging to deflect people from institutional care
- Q – Is there room in process to more fully define what is meant by person-centered services? A broad definition can very quickly turn into a checklist process. There is not a comprehensive understanding across the board – primary care, institutional, waiver settings - need principles and definitions to respond to.
  - A: Should be addressed in one of our first meetings
- C – How does Person-centered Planning apply to private duty nurses? Person and family choose hours of nursing to use. Person-centered Planning is being pushed out of the way by budgetary constraints. Resources need to be available to provide services centered around the person, reimbursements are so low.
- Q – Does accessible language apply only to in-person counseling?
  - A: Issues with written notices being sent only in English, recommendation to provide "if you don't speak English, call this number" in several languages.
- Q – Fear we will end up with a telephone book of a service plan. There is a difference between a service plan, clinical file and clinical record, need to understand the requirements.

    - A: Differentiation between service or support plan and documentation of how provider will implement plan.
  - Q – All subcommittee tasks must be accomplished by January? What are the Phase 1, 2, 3 timelines?
    - A: We do not have deadlines for achieving phases 1, 2, 3. The ultimate goal is to accomplish goals by end of the calendar year
    - A: There is a process for addressing external requirements to the Feds, we will keep you informed as the process evolves
  - Q – Are current processes really person-centered? What are the areas where we really need to focus?
    - C: Stakeholder shared experience with provider: My goal was to go to graduate school, and was told that wasn't an option and that I should receive SS Disability. I appreciate the goal of Person-centered Planning, but it must be a transition. If treatment provider genuinely feels consumer has goal that isn't realistic, how do you at least account for what client says is their goal?
    - C: Stakeholder reviews Individual Service Plans (ISP) for those who transition from state operated facilities. They are very rich and person-centered, but when review ISP with current provider, a lot is cut and paste, loses person-centered richness developed in the Community Resource Associates (CRA) process. Focus on best practices from CRA and use for other service providers.
    - C: CRA is now called Active Community Care Transition (ACCT) plan. The person or group to facilitate Person-centered Planning process wasn't necessarily a case manager. It was a challenge to capture everyone's input for a rich plan and make sure information translated to Person-centered Planning service plan.
  - Q – How can we make this applicable to hospital discharge? Pre-screening is rushed, decisions may be different. It is a weak point in the system, how to use the tool when under duress.
    - A: That is a longer term goal, will need to bring in the hospitals eventually, the immediate tools are managed care contracts
- **SERVICE DEFINITIONS**
  - Process: 1) crosswalk services across waivers to understand approach; 2) make high-level decisions on how to integrate services; 3) develop definitions and qualifications, training requirements
- Comments and Q&A:
  - C – 1115 comments align with "what to address later" slide. People feel those topics are more urgent, please provide more detail on how they will be addressed.

- A: Carved into scope of the LTSS subcommittee
- A: Have to start with which services
- A: Other initiatives, such as the Uniform Assessment Tool (UAT) efforts, Person-centered Planning infrastructure, have an impact
- A: These breakthrough groups are foundational for the discussions that must happen

- Q – Will crosswalk include services that are not covered by waivers but are important for LTSS?
  - A: Crosswalk just includes existing services
  - A: Will be included in high-level decisions, will address other services that need to be included
- C– In other meetings we have discussions about not having siloes. Based on populations not waivers.
  - A: Start with 1115, then cover all services under 9 waivers
  - A: Complicated for consumers to make best choice, the goal is to make the process as simplified as possible
  - A: Crosswalk important to see where services overlap, to see where you should have independent services and where they merge
- C– Discussion about service cost maximums, affects consumer decision if prices are different.
  - Will take phased approach for service definitions and qualifications
  - Then discussion on rates, linked to service cost maximums
- Q – People with substance abuse and serious mental illness are not currently included in waivers. We don't have existing LTSS infrastructure, and mental health case management is a Medicaid service, substance abuse is not. How will populations be incorporated into LTSS?
  - A: Goal is to treat and look at people holistically.
  - A: How we integrate 132 services into this picture is what we have to figure out and discuss together
  - A: Just because mental health does not have a waiver, it does not exclude you from other waiver services
- Q – Do we know when in the process we will bring participant self-direction and rates back up into the discussion? These are critical issues for consumers.
  - A: Some other work is deemed foundational to get to those discussions
  - A: Important to have these discussions as soon as possible
- Q – In doing the crosswalk, one of the services is Personal Assistant self-directed services, how do you pull those out?

- A: Talk about in context of crosswalk, flag services that we need to talk about, expand to other services
- A: Might include on crosswalk when determining list of services and definitions

- Q – If these are decisions that we're making separately, if we are defining services independent of rates, we may end up cutting rates?
  - A: It will be an iterative process - draft definitions and qualifications, then go to rates, then may alter service definitions once they are priced out
- Q – Will we send service definitions to Feds before we discuss rates?
  - A: The State and federal CMS have held some internal meetings.
  - A: What we demonstrate for 1115 can change
- Q – What are the assumptions for proposed dollar amounts in waivers? Do they inform the base from which we work?
  - A: We will have to get back to you with specifics, folks in GOHIT office can better address
- Q – Has there been a federal response to the 1115 waiver submittal?
  - A: Yes, we have had 2 meetings with federal CMS on waiver application, first discussions of many
  - A: Started negotiation phase, hope negotiation will be short, but we don't control that, could take 9 months, maybe longer, we're trying to expedite the process
- Q – Are there general comments from CMS?
  - A: Cristal Thomas was on the calls, we don't have details
- Q – Are we talking about provider qualifications and service definitions for the overall provider? Do they need to be accredited? At what point are you talking about certain staff positions, requirements for certifications?
  - A: Both, staff qualifications and requirements for agency as a whole, credentialing and accreditation
- C – In the Illinois Emergency Department (IED) system, IL is a "data free zone". We don't have any data for making decisions on how to blend services in. With 30 service definitions, maybe those aren't the choices that people and families want. Just because funding groups services together doesn't mean that's what families want. Need new language to break out of waiver world that we're in.
- Q – 1115 waiver is combining 9 waivers, administered by GOHIT. We're also making comments about managed care, are we turning 1115 over to managed care entities?

- A: GOHIT is organizing this process, waivers are still in the Department of Healthcare and Family Services (HFS)
- A: Service delivery platform is moving rapidly toward managed care. There are several entities – Coordinated Care Entities (CCEs), Managed Care Community Networks (MCCNs), Managed Care Organizations (MCOs) and Accountable Care Entities (ACEs)
- A: Have to look at all of this through the managed care lens. This is not new to states, other states have done this. We're implementing this through traditional managed care platform, but still have fee for service structures in place. We will be working on a dual platform for a while.

- C – Concern that we are putting total system in managed care. States are looking to Illinois since we are doing this in a totally different way.
- C – Many people within Medically Fragile, Technology Dependent (MFTD) waiver receive services as a wrap-around to private insurance. Already have managed care under those policies, concerned that we have managed care twice here, can create complications. How to fit MFTD population into broader group.
- C – Provider and advocacy community was told that LTSS are still carved out, concerns in DD community.
- Q – Went through 3 rounds of recommendations, made comments that UAT is an oxymoron to Person-centered Planning, extremely concerned.
  - A: Can apply structure and standardization and maintain flexibility and individual nature of process
  - A: Hawaii example – 'talk story' process, take advantage and build into process. Need consistent forms to make reliable eligibility determinations, but can incorporate Person-centered Planning components. Starts at the beginning, setting expectations, main goal is to get to know the individual. Can fold in standardized requirements but flexible enough to capture individual information.

NEXT STEPS

- Working on graphic for timeframe and deliverables, coordinating drivers
- Discussing potential to create separate process for consumer engagement, looking for foundation support
- Next meeting: BIP CFCM/PCP Breakout meeting July 25, 1:00 – 3:00pm
  - Will send invite to full LTSS Subcommittee

5. Meeting End

Meeting Scheduled End: 12:00 PM

Meeting Actual End: 12:02 PM

6. NEXT MEETING

Next Meeting:
CFCM/PCP Breakthrough Group: Friday, July 25, 1:00 – 3:00 pm
Chicago: 401 S Clinton, 7th Floor Conf Rm
Springfield: Bloom Building, 3rd Floor, Large Video Conference
Dial-In: 888-494-4032 pc 806 832 4601#

Service Definitions Breakthrough Group: Friday, August 1, 9:00 – 11:00 am
Chicago: Bilandic Building, 160 N. LaSalle St., 10th Fl.
Springfield: IL State Library, 300 S. Second St., 4th Floor, Rooms 403 and 404